



Physical Examination QualChart®

Illinois Valley Community Hospital

* Printed:
10/4/2016 15:58
Time/Date Seen
(If Different):

Mode of
Arrival:
☐ EMS
☐ Other

Instructions: Circle pertinent positive findings. Exclude pertinent negative findings. INDICATORS: * Hx ▲ PQRS
Vital Signs: Stable except: BP _____ Pulse _____ R Rate _____ Temp _____
Pulse Ox: Normal Hypoxic Not Applicable _____ % on Room Air or O₂ @ _____ L/min
Cardiac Monitor: Rate: NSR Brady Tachy Rhythmic Sinus Afb Junctional Ectopy: None PVCs PACs

HISTORY:

HX from Patient Unobtainable due to: Dementia Altered Mental Status Extremis Other: _____
HX from: Patient Family / Caretaker EMS Interpreter Caseworker LMP: _____

CHIEF COMPLAINT: This is a 3 year old male / female who presents for a physical examination for School Work DCFS (Once if Appropriate)
Any Complaints: Yes / No wellness check

ONSET/DURATION Started _____ Min Hours Days Weeks Ago Still Present Resolved Worse Since: _____
TIMING Constant Intermittent Episodes Lasting _____ Sec Min Hours Days Weeks none
SEVERITY Initially: Mild Moderate Severe Currently: Mild Moderate Severe
LOCATION _____
CHARACTER _____
AGGRAVATING _____
ALLEVIATING _____
ASSOCIATED SIGNS AND SYMPTOMS Negative

RELATED HX Abuse No Other Known History - Patient in DCFS Custody

REVIEW OF SYSTEMS:

Pertinent Positives

Constitutional	Neg	Fever	Chills
Eyes	Neg	Photophobia	Blurred Vision
ENT	Neg	Sore Throat	Ear Ache
CV	Neg	Palpitations	Chest Pain
Resp	Neg	SOB	Cough
GI	Neg	Vomiting	Diarrhea
GU	Neg	Dysuria	Hematuria
MSkeletal	Neg	Arthralgia	Myalgia
Skin	Neg	Rash	Bruising
Neuro	Neg	Headache	Weakness
Psych	Neg	Anxious	Depressed

Additional Pertinent History:

PCP / Managing Physician(s): _____
Referred to ED / Clinic by: PCP / Telephone Referral / Other _____
Previous Visit for Same Complaint to ED / Clinic / PCP / In-Patient Within
72 Hours / _____ Days Dx / Rx _____

DCFS wait a physical exam.
PT active, playful.

All other systems reviewed and negative: Yes No

Levels 2-3: 1 System Level 4: 2 Systems Level 5: 10 Systems / Disclaimer

Rx/Treatment Compliant

PAST MEDICAL HISTORY:

Previously Healthy

DNR / Comfort Care Only

Endocrine	DM I	DM II	Hypothyroid	Hyperthyroid	Dyslipidemia
CV	CAD / MI	HTN	CHF	Afib	DVT
Respiratory	COPD	Asthma	Bronchitis	Pneumonia	PE
GI / GU	PUD / GERD	GI Bleed	Urosepsis	Diverticulitis	Gall / Kidney Stones
Neuro / Psych	TIA / CVA	Migraine	Anxiety	Depression	Chronic Kidney Dx
Cancer	Lung	Colon	Breast	Prostate	Seizure
Surgical Hx	None	Unknown			Bipolar Disorder

PMH / FH / SH Levels 1-3: 0 Level 4: 1 Level 5: PMH plus FH or SH

Immunizations: Unknown Tetanus UTD Not UTD
* Pneumococcal * Influenza within 12 months

FAMILY HISTORY:

Negative

Heart / HTN _____
Diabetes _____
Other: _____

SOCIAL HISTORY:

Negative

Smoking _____ ppd x _____ yrs. * Patient Advised to Stop
Cessation Counseling Time: 3+ min - 10 min / 10+ min.
* ETOH / Drug Use _____
Occupation: _____
Lives: Alone With Family At Nursing Home

KRAMER, MADELINE H

VISIT ID: 11216788

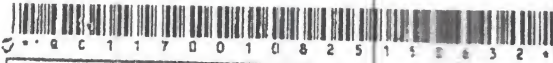
01/20/2013 3Y/F

ATT. SABIR, MUHAMMAD

PCP: OUT OF TOWN, PHYSICIAN

MRN: 261617

DATE 10/18/2016

**PHYSICAL EXAMINATION:**

EXAM LIMITED DUE TO: Dementia

Physical Examination QuickChart®

Illinois Valley Community Hospital

Altered Mental Status

Extremis

Other:

Complaint-Specific Findings

System	Normal Findings	Abnormal Findings
Appearance	Normal	Ill-appearing: Mild / Mod / Severe
Eyes	Normal	Pain Distress: Mild / Mod / Severe
ENT	Normal	Obese / Thin / Cachectic
Neck	Normal	R Pupil / L Pupil
Respiratory	Normal	Conjunctiva Inflamed
Cardiovascular	Normal	TMs Occluded
GI / GU	Normal	Rhinorrhea / Epistaxis
Musculoskeletal	Normal	Erythema / Erosions / Dry Mucosa
Skin	Normal	Nonsupple
Neuro	Normal	Airway Constructed
Psychiatric	Normal	Crackles @

DIFFERENTIAL DIAGNOSES:

Consideration of the following conditions may be warranted for the presenting problem; they are not final diagnoses.

RE-EVALUATION:

Pain Scale (0-10)

Time: Unchanged Improved Worse VSS

Time: Unchanged Improved Worse VSS

PHYS. NOTIFICATION/CONSULTS:

Chart Copy Available to Admit Care Providers

Discussed disposition/case/management of patient with:

Name: [Signature] at a.m. / p.m.

Name: [Signature] at a.m. / p.m.

Admit/Transition Orders Written by ED Provider: Yes / No

Reviewed with:

Admit to: Consult Follow-up:

DISPOSITION: *DISPOSITION DECISION TIME:

Discharge: Home Work Nursing Home Deceased AMA #LWBS

Admit: ED Obs InPt Unit: ICU OR Tele Floor Condition: Stable Unstable

Patient Endorsed To/Discussed With: @ a.m. / p.m.

Patient Stabilized Within Hospital's Capabilities/Transferred to:

Transfer Form Completed

Disposition Rationale:

Discussed with: Patient Family Other:

After-Care Instructions Given to & Follow-Up Care Discussed w/Patient At Discharge

ED PHYSICIAN DIAGNOSES:

1. Normal Exam.

2.

3.

Critical Care Provided: 30-74 min / 75-104 min / min (Excludes time required for other billable procedures)

SIGNATURE:

I have reviewed available Ancillary / Nursing Staff documentation.

TIME:

PA / NP / Resident

MD/DO

MD/DO

DATE:

(If different than above)

Teaching Physician - I performed a history & physical examination of the patient and discussed the management with the Resident. I reviewed the Resident's note and agree with the findings and plan of care, except as I have documented. (Initials)

Chart Completed: Yes No

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This form is to assist the healthcare provider's documentation of clinical care and treatment. It is not intended to supplant that judgement or create a standard of care.

DATE 10/18/2016

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